



CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE
**BOARD OF MENTAL HEALTH AND CHEMICAL
DEPENDENCY PROFESSIONALS**

TELEPHONE: (302) 744-4500
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**APPLICATION FOR LICENSURE AS AN ASSOCIATE MARRIAGE & FAMILY THERAPIST
INSTRUCTION SHEET FOR APPLICANTS AND SUPERVISORS**

Before completing the application for licensure as an Associate Marriage and Family Therapist (LAMFT), both you, as the applicant, and your supervisor(s) should carefully read this entire instruction sheet—including the marriage and family counseling experience and supervision requirements explained below. The hours of experience and supervision that you will be completing are documented on the **WRITTEN PLAN FOR MARRIAGE AND FAMILY EXPERIENCE AND SUPERVISION** section of the application. To assure that both you and your supervisor(s) understand the plan, both must sign off on it.

**Marriage and Family Therapist
POST-MASTERS THERAPY EXPERIENCE REQUIREMENTS**

When applying by examination, you must arrange for the Board office to receive verification that you have provided the required hours of post-Masters marriage and family counseling.

- You must have post-Masters marriage and family counseling experience of at least 3,200 hours over a period of at least two, but not more than four, years. Of the 3,200 hours, at least 1,600 hours must have been under professional direct supervision.
- The supervisor(s) must be one of these:
 - Delaware-licensed Marriage and Family Therapist, or
 - American Association for Marriage and Family Therapy (AAMFT) “approved supervisor,” or
 - AAMFT “approved supervisor” candidate, or
 - Licensed marriage and family therapist from another state who has held a license in good standing for at least five years in that state and who has passed the Association of Marital and Family Therapy Regulatory Boards (AMFTRB) exam.

If none of the above supervisors is available, a licensed clinical social worker, licensed psychologist, licensed professional counselor of mental health, or licensed physician specializing in psychiatry with training in marriage and family therapy supervision may act as a supervisor.

- ***Unless the supervisor is an AAMFT “approved supervisor,” the Delaware Board must approve the supervisor.***
- Any hours you complete under the supervision of a person who does not fit into one of the above categories will **not** count toward fulfillment of the required 1,600 hours of supervised experience but may count toward the 1,600 hours of unsupervised experience.
- When the hours under **all** approved supervisors are combined, the 1,600 hours must span a period of *at least two but not more than four consecutive years*. The hours must break down as follows:
 - 500 hours of couple and family therapy
 - 500 hours of individual therapy
 - 500 hours of any combination of couple and family **or** individual therapy (in addition to the above).
 - 100 hours of face-to-face clinical supervision with your approved supervisor(s)

For more information about the direct supervision requirements, refer to Section 5.1.2 of the Board's [Rules and Regulations](#).

The hours of experience and supervision that the applicant has not yet completed are documented on the **Written Plan for Marriage and Family Therapy Experience and Supervision**. To assure that both the applicant and the supervisor understand the plan, both must sign off on it.

When answering the experience questions on the application, it is important for both applicant and his or her supervisor(s) to understand the following:

- The hours of direct supervision that the applicant has already completed plus the planned hours of direct supervision (as documented in the **Written Plan**) must total *at least* the mandatory 1,600 hours of professional direct supervision. In addition,
 - The applicant's completed hours of couple and family therapy plus the planned hours of couple and family therapy sessions must total *at least* 500 hours.
 - The applicant's completed hours of individual therapy plus the planned hours of couple and family therapy sessions must total *at least* 500 hours.
 - The applicant's completed hours of any combination of couple and family or individual therapy plus the planned hours of couple and family or individual therapy must total *at least* 500 hours.
 - The applicant's completed hours of face-to-face clinical supervision with your approved supervisor(s) plus the planned hours of face-to-face supervision must total *at least* 100 hours.
- The hours of experience the applicant has already completed—whether or not under professional direct supervision—added to the hours of experience in the **Written Plan** must total the required hours for licensure.
- **All of the required hours, whether or not supervised—must span a period of not less than two but no more than four years.**
- When asked to enter hours of experience or supervision, you must calculate and enter an actual number of hours. Answers such as “40 hours/week” will **not** be accepted.

Both the applicant and supervisor(s) should carefully follow the instructions for completing the forms. Incomplete or incorrectly completed forms delay processing of your application. The Board will not accept a resume in lieu of or in addition to the forms.

Requirements for All Applications

- ☐ Submit completed, signed and notarized [Application for Licensure as an Associate Marriage and Family Therapist](#).
 - Applications that are incomplete, unsigned or not notarized will be rejected.
- ☐ Enclose the non-refundable [processing fee](#) by check or money order made payable to the "State of Delaware."
 - Applications not accompanied by the required fee will be rejected.
- ☐ Complete the *Criminal History Record Check Authorization* form to request State of Delaware and Federal Bureau of Investigation criminal background checks. Follow the instructions on the authorization form to arrange to be fingerprinted.
 - You must meet this requirement *even if* you recently had a criminal background check done for some other reason.
- ☐ Arrange for the Board office to receive a verification of licensure from each jurisdiction (state, U.S. territory, District of Columbia) where you now hold, or have ever held, a license to practice as a mental health professional.
 - You may use the *Verification of Licensure* form enclosed with this packet to request the verification.
- ☐ Arrange for the Board office to receive an official transcript from *each* college/university where you earned a Masters or doctoral degree in marriage and family therapy or any allied field, sent *directly* from the school to the Board office.
- ☐ Complete and submit the COAMFTE *Course Comparison Form* if **either** of these situations applies to you:
 - Your graduate program of studies is not accredited by the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE), **or**
 - Your degree from a nationally accredited college or university is **not** in marriage and family therapy but in a related discipline such as counseling, social work, psychology, or psychiatry.
- ☐ If you have passed the AMFTRB examination, arrange for the Board office to receive an official score transfer sent directly to the Board office from the Interstate Reporting Service, www.amftrb.org.
- ☐ If any of your supervisors is a marriage and family therapist who is *not* licensed in Delaware, arrange for the Board to receive proof that the supervisor has passed the AMFTRB exam and has five years experience as a marriage and family therapist.

- ☐ If you have never been issued a U.S. Social Security Number (SSN), submit a [Request for Exemption from Social Security Number Requirement](#).

The Privacy Act of 1974, Section 7, requires the following information to be given to all applicants: Applicants for any Delaware professional or occupational license, permit, registration or certificate (other than Gaming permits) are required to provide a U.S. SSN (29 Del. C. §8735(m)). The Division of Professional Regulation uses the SSN primarily to verify identity and safeguard personal information. It may also be used to enforce child support obligation (13 Del. C. §2216) and for other lawful purposes.

Requirements Related to Completed Experience

The following requirements document and verify how many hours of acceptable post-Masters experience in *marriage and family therapy* you have already accrued.

- ☐ Arrange for your supervisor(s) to complete and sign the page entitled **COMPLETED SUPERVISED EXPERIENCE HOURS**.
- ***The total number of post-Master's hours of marriage and family therapy that you have provided under professional direct supervision*** must be clearly stated. Providing only the dates of your employment is not sufficient.
 - If you had more than one period under different supervisors, have the approved supervisor for each period complete a box for the period during which he or she supervised you.

- ☐ You complete and sign the page entitled **COMPLETED UNSUPERVISED EXPERIENCE HOURS**.

Requirements Related to Written Plan for Marriage and Family Therapy Experience and Supervision

The following requirements document how many hours of post-Masters of marriage and family therapy experience – both under professional direct supervision and unsupervised – you still need to complete in order to meet the requirements for Delaware licensure as a Marriage and Family Therapist. Remember to add the planned hours to the completed hours to make sure that the totals meet the requirements for eventual licensure as a Marriage and Family Therapist.

- ☐ Arrange for the box entitled **Planned Supervised Hours** to be completed and signed by the supervisor(s) under whose supervision you will complete the hours.
- ☐ Complete the box entitled **Planned Unsupervised Hours** to document the experience that you plan to finish while not under the professional direct supervision.
- No verification of these planned unsupervised hours is required.



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APPLICATION FOR LICENSURE AS AN ASSOCIATE MARRIAGE & FAMILY THERAPIST

IDENTIFYING AND CONTACT INFORMATION

1. Full Name: _____
Last First Middle
2. Other Names Used: None ☐ _____
(Include maiden, prior married, alternate spellings)
3. Date of Birth (month/day/year): _____ Gender: Male ☐ Female ☐
4. Have you been issued a U.S. Social Security Number? Yes ☐ No ☐ If yes, enter your SSN: _____
If no, you must file a [Request for Exemption from Social Security Number Requirement](#).
5. Mailing Address: _____

City State Zip
6. Phone: _____ Home _____ Work _____ Email: _____ None ☐

GRADUATE EDUCATION – All applicants complete this section

7. Have you earned a master's or doctoral degree in marriage and family therapy or in an allied field? Yes ☐ No ☐ If yes, enter this information about **all graduate** degrees you have received.

EDUCATIONAL INSTITUTION	GRADUATE DEGREE	DATE AWARDED	FIELD OF STUDY

Arrange for the Board office to receive an official transcript sent *directly* from *each* college/university listed to the Board office.

8. Is your graduate program of studies accredited by the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE)? Yes ☐ No ☐ If no, **complete and submit the COAMFTE Course Comparison Form.**

EXAMINATION – All applicants complete this section.

9. Have you passed the AMFTRB examination? Yes ☐ No ☐ If yes, **arrange for the Board office to receive an official score transfer sent directly to the Board office from the Interstate Reporting Service, www.amftrb.org.**

LICENSURE HISTORY – All applicants complete this section.

10. Have you ever been denied licensure in any other jurisdiction? Yes ☐ No ☐ If yes, explain fully: _____

11. Have you ever held a license to practice as a marriage and family therapist in any jurisdiction other than Delaware? Yes ☐ No ☐ If yes, enter the following information about *each* license that you have ever held.

JURISDICTION	TYPE OF LICENSE HELD	LICENSE NUMBER	LICENSURE DATES	
			From	To

Arrange for the Board office to receive a verification of licensure from *each* jurisdiction where you have ever held a marriage and family therapist license.

DISCLOSURES

12. Have you received any administrative penalties regarding your actions as a licensed, registered or certified mental health provider, including but not limited to fines, formal reprimands, license suspensions or revocation (except for license revocations for nonpayment of license renewal fees), probationary limitations, and/or have you entered into any "consent agreement" which contains conditions placed by a Board on your professional conduct, including any voluntary surrender of a license? Yes ☐ No ☐ **If yes, enclose a detailed explanation of all such penalties.**
13. Are any disciplinary actions pending against you? Yes ☐ No ☐ **If yes, attach a detailed explanation of any pending actions.**
14. Have you done any of the following grounds for discipline:
- committed or knowingly cooperated in a fraud or material deception in order to acquire a license? Yes ☐ No ☐
 - impersonated another person holding a license? Yes ☐ No ☐
 - allowed another person to use your license? Yes ☐ No ☐
 - aided or abetted an unlicensed person to represent himself or herself as a licensee? Yes ☐ No ☐
- If yes to any, enclose a detailed explanation of the violations.**
15. Do you currently excessively use or abuse drugs or have you done so in the past 3 years? Yes ☐ No ☐ **If yes, enclose a detailed explanation.**
16. Have you engaged in an act which involved consumer fraud or deception, restraint of competition, or price fixing? Yes ☐ No ☐ **If yes, enclose a detailed explanation.**
17. Do you have any impairment related to drugs or alcohol or a finding of mental incompetence by a physician that would limit your ability to act as a marriage and family therapist or associate marriage and family therapist in a manner consistent with the safety of the public? Yes ☐ No ☐ **If yes, enclose a detailed explanation.**
18. Have you been penalized for any willful violation of the code of ethics adopted by the Board, the NBCC code of ethics or other similar professional mental health counseling standard? Yes ☐ No ☐ **If yes, enclose a detailed explanation.**
19. I have read and understand the Rules and Regulations of the Delaware Board of Mental Health and Chemical Dependency Professionals pertaining to the licensure for which I am applying. Yes ☐ No ☐
20. Are you presently in violation of any Rule and Regulation set forth by the Delaware Board of Mental Health and Chemical Dependency Professionals? Yes ☐ No ☐ **If yes, enclose a detailed explanation of all such violations.**

DUTY TO REPORT

21. To obtain a license in Delaware, you must certify that you understand that you have a **mandatory** duty to report, in writing, within 30 days of becoming aware of information that you reasonably believe indicates that **any healthcare provider** including (but not limited to) any practitioner certified and registered to practice medicine in Delaware or licensed by the Board of Mental Health and Chemical Dependency Professionals
- has engaged, or is engaging, in conduct that would constitute grounds of discipline under their licensing laws, or
 - may be unable to practice with reasonable skill and safety to the public by reason of mental illness or mental incompetence, physical illness (including deterioration through the aging process or loss of motor skill), or excessive abuse of drugs (including alcohol).

I certify that I have read and understand [24 Del. C. §3018](#), [24 Del. C. §1730](#), [24 Del. C. §1731](#) and [24 Del. C. §1731A](#) and that I understand my *duty to report* to the Division of Professional Regulation. Yes ☐ No ☐

22. To obtain a license in Delaware, you must certify that you understand that you have a **mandatory** obligation to make an immediate oral report to the Department of Services for Children, Youth and Their Families if you know of, or you suspect, child abuse or neglect under Chapter 9 of Title 16 and to follow up with any requested written reports.

I certify that I have read and understand [16 Del. C. §903](#) and that I understand my *duty to report*. Yes ☐ No ☐

23. To obtain a license in Delaware, you must certify that you understand that you have a **mandatory** duty to **self report** when your license to practice in another jurisdiction has been disciplined, surrendered, suspended or revoked.

I certify that I have read and understand [24 Del. C. §3009 \(a\)\(7\)](#) and that I understand my *duty to self report*.
Yes ☐ No ☐

EXPERIENCE AND SUPERVISION

24. List all current or former supervisor(s) who will verify the required post-Master's degree supervised experience that you have completed:

NAME	ADDRESS	PHONE	DEGREE

25. Is your clinical supervisor a Delaware-licensed Marriage and Family Therapist? Yes ☐ No ☐ If no, explain **in detail (1) the additional steps you took to secure a LMFT to supervise you and (2) why you are proposing another professional as your supervisor.** _____

26. The next several pages provide space to document the post-Master's marriage and family therapy experience that you have completed and that you plan to complete. Begin with your most recent experience and work backward. Remember that...

- Your supervisor(s) will complete the pages for your planned **supervised** experience.
- You will complete the pages for your planned **unsupervised** experience.
- When *all* hours are added together, your planned hours under professional direct supervision plus your planned hours of unsupervised marriage and family therapy experience must total 3,200 hours.
- *All* of the planned hours—whether or not under supervision—must span a period of not less than two but no more than four years.

If you need more room for additional periods, you may copy this page.

PLANNED DIRECT SUPERVISION – To be completed by *Proposed MFT Supervisor* only

INSTRUCTIONS

The proposed clinical supervisor completes this **PLANNED DIRECT SUPERVISION** form to document hours that he or she will be directly supervising a LAMFT.

The planned hours entered in the **Written Plan** must total at least the mandatory minimum 1,600 hours of direct supervision.

- The planned hours of couple and family therapy entered in the **Written Plan** must total at least 500 hours.
- The planned hours of individual therapy entered in the **Written Plan** must total at least 500 hours.
- The planned hours of combined couple and family therapy or individual therapy entered in the **Written Plan** must total at least 500 hours.
- The planned hours of face-to-face supervision entered in the **Written Plan** must total at least 100 hours.

All required hours—completed plus planned whether or not directly supervised—must span a period of not less than two but no more than four years.

INFORMATION ABOUT PROPOSED MFT SUPERVISOR

1. Supervisor Name: _____
Last First Middle

2. Check all that apply to you:

- ☐ I am an American Association for Marriage and Family Therapy approved supervisor.
☐ I am an American Association for Marriage and Family Therapy approved supervisor in training.
☐ I was approved by the Delaware Board to supervise. Enter approval date: _____
☐ Other: _____

3. Provide the following information about your professional licensure:

✓	LICENSES HELD (check all that apply)	JURISDICTION	LICENSE #	ISSUE DATE
<input type="checkbox"/>	Marriage and Family Therapist			
<input type="checkbox"/>	Clinical Social Worker			
<input type="checkbox"/>	Clinical Psychologist			
<input type="checkbox"/>	Professional Counselor of Mental Health			
<input type="checkbox"/>	Psychiatrist trained in marriage and family therapy			

If you are a marriage and family therapist *not* licensed in Delaware, the Board requires proof that you have passed the AMFTRB exam and have five years experience as a marriage and family therapist.

4. Are you a Delaware-licensed LMFT? Yes ☐ No ☐ If yes, enter your license number: FT - _____
If no, describe your supervisory experience and credentials:

5. Supervisor's Practice Name (if applicable): _____

6. Practice Address: _____

City State Zip

7. Phone: _____ Email: _____

DIRECT SUPERVISION HOURS

8. Enter the dates of planned post-Master's experience that the applicant will provide under your direct supervision: From _____ To _____
Month/Year Month/Year

This period must not span more than four years.

9. During the period entered above, how many total hours of **marriage and family therapy** that the applicant will provide under your **direct professional supervision**: _____

If you need more room for additional periods, you may copy this page.

PLANNED DIRECT SUPERVISION, continued

10. Show how the total hours you entered in Question 9 will break out into the following categories:

- Couple and family therapy hours: _____
- Hours of face-to-face supervision: _____
- Hours of individual therapy: _____
- Combined couple and family therapy or individual therapy: _____

Answers such as "40 hours/week" will not be accepted.

11. I attest that I have discussed the following with the applicant before completing this form. Answer each question. **If you answer 'NO' or 'N/A' to any question, enclose a written statement explaining why.**

I have explained to the applicant that I have the training, credentials, and competence to provide supervision in Delaware.	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
I have discussed my role and responsibilities with the applicant. These include:	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
• Evaluating the applicant's clinical competence and preparedness to practice independently	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
• Ensuring that the applicant practices within the professional and ethical standards of the field	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
• Ensuring that the applicant is aware of the rules and regulations for practicing independently in Delaware	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
I have discussed a contingency plan for dealing with emergencies and crises.	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
I have explained my model and style of supervision to the applicant.	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
I have reviewed the supervisory feedback process, including performance appraisal, evaluation feedback, documentation, and feedback intervals.	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
I have explained how I will assess the applicant's comprehension of ethical, legal, and professional requirements.	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
I have ensured that the appropriate liability coverage is in place for the applicant and for myself.	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
I have developed a process to address any issues or concerns regarding the applicant's performance, including the utilization of a third-party to remediate any performance issues, consultation for additional assistance, or options to address concerns.	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
I have explained my role in endorsing the applicant for licensure or employment based on the applicant's demonstrated competence and qualifications and that I will not endorse an applicant whom I believe to be impaired in any way that would interfere with the performance of the duties associated with the endorsement.	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
I have explained to the applicant that I have the training, credentials, and competence to provide supervision to a LACMH/LAMFT pursuant to the regulations of Delaware Board of Mental Health and Chemical Dependency Professionals.	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
I have explained how I will assess the applicant's comprehension of ethical, legal, and professional requirements pursuant to the regulations of Delaware Board of Mental Health and Chemical Dependency Professionals.	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
I have the ethical and legal authority to access confidential client information of the LACMH/LAMFT. Note: For supervisors who are not employees of the clinical setting where LAMHC/LAMFT is seeing clients a written agreement between the supervisor and agency should be executed.	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>

CERTIFICATION

I certify that I have personally completed this information and that the information provided herein is accurate and complete to the best of my knowledge.

Clinical Supervisor Signature: _____ **Date:** _____

If you need more room for additional periods, you may copy this page.

**PLANNED UNSUPERVISED MARRIAGE AND FAMILY THERAPY EXPERIENCE – To be completed by
Administrative Supervisor only**

INSTRUCTIONS

If the applicant does not have 30 post-Masters credit hours in the counseling field, an administrative supervisor completes the **PLANNED UNSUPERVISED MARRIAGE AND FAMILY SERVICES EXPERIENCE** form to document estimated additional hours of professional marriage and family services experience that the applicant will accrue while **not** under the direct supervision of an approved supervisor. Remember that these additional hours, when added to the 1600 or more hours of supervised experience verified by the approved supervisor(s), must total at least 3200 hours.

INFORMATION ABOUT PERSON VERIFYING EXPERIENCE

1. Name: _____
Last First Middle
2. Practice Name Where Experience Will Occur: _____
3. Describe Practice: _____

Examples include group practice, community mental health agency.
4. Practice Address: _____

City State Zip
5. Phone: _____ Email: _____

EXPERIENCE HOURS

6. Enter the period when you will supervise the LAMFT: From _____ To _____
Month/Year Month/Year
7. Calculate and enter the total number of hours of marriage and family therapy services that the applicant will engage in during this period while not under direct supervision of an approved supervisor: _____

***This period must
not span more than
four years.***

***Answers such as "40
hours/week" will not be
accepted.***

CERTIFICATION

I certify that I have personally completed this information and that the information provided herein is accurate and complete to the best of my knowledge.

Administrative Supervisor Signature: _____ **Date:** _____

To ensure consideration of your license application at the next Board meeting, the Board office must receive all of these items no later than 4:30 PM ten full working days before the Board's meeting date:

- Completed, signed and notarized application form
- Fee payment
- All required supporting documentation.

Applications that are not complete within 12 months of filing may be considered abandoned and discarded. When your application is complete, please allow 4-8 weeks to receive your license.

AFFIDAVIT

The undersigned applicant for Licensed Associate Marriage and Family Therapist, being sworn, deposes and affirms that he or she is the person who executed this application; that the statements contained on this application are true in every respect; that he or she has not suppressed or withheld information that might affect this application; that he or she will abide by the laws and the ethical standards of this profession; and that he or she has read and understands this statement.

The applicant further affirms that he or she has read and understands the Written Plan for Professional Counseling and Supervision contained in the application and that he or she will promptly report any change in the plan to the Board office.

The applicant authorizes all jurisdictions to release any and all information regarding his/her disciplinary history and current status to the Delaware Board of Mental Health and Chemical Dependency Professionals.

Signature of Applicant: _____ Date: _____

State of _____ County of _____

Sworn to before me and subscribed in my presence this _____ day of _____ 2_____.

Signature of Notary: _____

SEAL

My commission expires: _____

**APPLICATIONS THAT ARE UNSIGNED, NOT NOTARIZED, INCOMPLETE OR NOT ACCOMPANIED BY THE
REQUIRED FEE WILL BE REJECTED.**



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COAMFTE COURSE COMPARISON FORM

All candidates must have at least one course minimum (three semester hours, four quarter hours, or 45 didactic contact hours required) in each of the ten categories to be eligible to be licensed as a marriage and family therapist. See Section 6.2.2.1 in the Board's [Rules and Regulations](#).

1. **FOUNDATIONS OF RELATIONAL/SYSTEMIC PRACTICE, THEORIES & MODELS:** Courses in this area must be six semester credits and are intended to facilitate the development of competencies in the foundations and critical epistemological issues of MFTs. Areas of study include the historical development of the relational/systemic perspective, contemporary conceptual foundations of MFTs, and early and contemporary model of MFT, including evidence-based practice and the biopsychosocial perspective.

EDUCATIONAL INSTITUTION	COURSE #	COURSE TITLE	TO/FROM DATES	CREDIT HOURS	CONTACT HOURS

2. **SYSTEMIC/RELATIONAL ASSESSMENT & MENTAL HEALTH DIAGNOSIS AND TREATMENT:** Courses in this area are intended to facilitate the development of competencies in traditional psycho-diagnostic categories, psychopharmacology, the assessment, diagnosis, and treatment of major mental health issues as well as a wide variety of common presenting problems including addiction, suicide, trauma, abuse, intra-familial violence, and therapy for individuals, couples, and families managing acute chronic medical conditions, utilizing a relational/systemic philosophy.

EDUCATIONAL INSTITUTION	COURSE #	COURSE TITLE	TO/FROM DATES	CREDIT HOURS	CONTACT HOURS

3. **BIOPSYCHOSOCIAL HEALTH & DEVELOPMENT ACROSS THE LIFE SPAN:** Courses in this area focus on individual and family development, human sexuality, and biopsychosocial health across the life span.

EDUCATIONAL INSTITUTION	COURSE #	COURSE TITLE	TO/FROM DATES	CREDIT HOURS	CONTACT HOURS

4. **DIVERSE, MULTICULTURAL AND/OR UNDERSERVED COMMUNITIES:** Courses in this area intended to facilitate the development of competencies in understanding and applying knowledge of diversity, power, privilege, and oppression as these relate to race, age, gender, ethnicity, sexual orientation, gender identity, socioeconomic status, disability, health status, religious, spiritual and/or beliefs, nation of origin or other relevant social categories. Courses in this area also includes practice with diverse, international, multicultural, marginalized, and/or underserved communities, including developing competencies in working with sexual and gender minorities and their families as well as anti-racist practices.

EDUCATIONAL INSTITUTION	COURSE #	COURSE TITLE	TO/FROM DATES	CREDIT HOURS	CONTACT HOURS

5. **CLINICAL TREATMENT WITH INDIVIDUALS, COUPLES AND FAMILIES:** Courses in this area are intended to facilitate the development of competencies in treatment approaches specifically designed for use with a wide range of diverse individuals, couples, and families, including sex therapy, same-sex couples, working with young children, adolescents and elderly, interfaith couples, and focuses on evidence-based practice. Courses must include content on crisis intervention.

EDUCATIONAL INSTITUTION	COURSE #	COURSE TITLE	TO/FROM DATES	CREDIT HOURS	CONTACT HOURS

6. **PROFESSIONAL IDENTITY, LAW, ETHICS & SOCIAL RESPONSIBILITY:** Courses in this area address the development of a MFT Identity and socialization, and facilitate the development of competencies in ethics in MFT practice, including understanding and applying the AAMFT Code of Ethics and legal responsibilities.

EDUCATIONAL INSTITUTION	COURSE #	COURSE TITLE	TO/FROM DATES	CREDIT HOURS	CONTACT HOURS

7. **RESEARCH & EVALUATION:** Courses in this area are intended to facilitate the development of competencies in MFT research and evaluation methods, in evidence-based practice, including becoming an informed consumer of couple, marriage, and family therapy research. If the program's mission, goals and outcomes include preparing students for doctoral degree programs, the program must include an increased emphasis on research.

EDUCATIONAL INSTITUTION	COURSE #	COURSE TITLE	TO/FROM DATES	CREDIT HOURS	CONTACT HOURS

8. **CONTEMPORARY ISSUES:** Courses in this area are intended to facilitate the development of competencies in practice within defined contexts (e.g., healthcare settings, schools, military settings, private practice) and/or nontraditional MFT professional practice using therapeutic competencies congruent with the program's mission, goals and outcomes (e.g., community advocacy, psycho-educational groups). Courses in this area are also intended to facilitate the development of competence in multidisciplinary collaboration.

EDUCATIONAL INSTITUTION	COURSE #	COURSE TITLE	TO/FROM DATES	CREDIT HOURS	CONTACT HOURS

9. **COMMUNITY INTERSECTIONS & COLLABORATION:** Courses in this area are intended to facilitate the development of competencies in emerging, and evolving contemporary challenges, problems, and/or recent developments at the interface of Couple or Marriage and Family Therapy knowledge and practice, and the broader local, regional, and global context. This includes such issues as immigration, technology, same-sex marriage, violence in schools, etc.

EDUCATIONAL INSTITUTION	COURSE #	COURSE TITLE	TO/FROM DATES	CREDIT HOURS	CONTACT HOURS

10. **CLINICAL SUPERVISED EXPERIENCE IN MARRIAGE & FAMILY THERAPY:** Courses in this area must be 9 semester credit hours and are intended to provide clinical supervision (live or recorded) to students providing 300 hours of direct client contact (150 with couple or families).

EDUCATIONAL INSTITUTION	COURSE #	COURSE TITLE	TO/FROM DATES	CREDIT HOURS	CONTACT HOURS



CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE
**BOARD OF MENTAL HEALTH AND CHEMICAL
DEPENDENCY PROFESSIONALS**

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV
EMAIL: customerservice.dpr@state.de.us

VERIFICATION OF LICENSE

Send a separate form to *each* jurisdiction other than Delaware where you have ever held a license to practice as a mental health practitioner. Before sending this form to the jurisdiction, it is advisable to find out if the jurisdiction requires a fee to provide a license verification. You may duplicate this form.

<p>This section to be completed by applicant.</p>	<p>Last Name: _____ First: _____ Middle: _____</p> <p>SSN: _____ Date of Birth: _____</p> <p>Other Name(s) Used: _____</p> <p>Jurisdiction Where Licensed: _____</p> <p>License/Registration Number(s) in Jurisdiction Named Above: _____</p> <p>I am applying for Delaware licensure as a:</p> <p><input type="checkbox"/> Professional Counselor of Mental Health <input type="checkbox"/> Associate Counselor of Mental Health</p> <p><input type="checkbox"/> Chemical Dependency Professional <input type="checkbox"/> Associate Marriage and Family Therapist</p> <p><input type="checkbox"/> Marriage and Family Therapist</p> <p>Before my application can be reviewed, verification of my license in good standing is required. I am authorizing the release of the information requested on this form to be sent to the Delaware Board of Mental Health and Chemical Dependency Professionals.</p> <p>Applicant Signature: _____ Date: _____</p>
<p>This section to be completed by Licensing Authority.</p>	<p>Our records indicate that the applicant named above was licensed in the State/Province/Jurisdiction of: _____ as a (type of license) _____</p> <p>Registration/License Number: _____</p> <p>Issue Date (month/day/year): _____ Expiration Date (month/day/year): _____</p> <p>Has the licensee ever been subject to any disciplinary action or had his/her license revoked or suspended?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please enclose a certified copy of the board's final order with this license verification.</p> <p>Are any disciplinary proceedings or unresolved complaints pending against the licensee? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>I certify that the statements contained herein are true and correct.</p> <p>Printed Name of Official: _____</p> <p>Signature of Official: _____ Date: _____</p> <p>Title: _____</p> <p>Phone: _____ Fax: _____ Email: _____</p>
<p>AFFIX OFFICIAL SEAL HERE</p>	

Return completed, signed and sealed form *directly* to the Board office at the address above.

Instructions for Requesting a Criminal Background Check

Both State of Delaware and Federal Bureau of Investigation criminal background checks are required.

Applicant Notification

Your fingerprints will be used to check the criminal history records of the Federal Bureau of Investigation (FBI). You have the opportunity to challenge the accuracy of the information contained in the FBI identification record. See [Title 28, CFR 16.34](#) for the procedure to obtain a change, correction or update in the FBI record.

Locations

Kent County – Primary Facility

State Bureau of Identification
Blue Hen Mall & Corporate Center
655 S. Bay Rd. Suite 1B
Dover, DE 19901

Walk-ins accepted: Mon 8:30 am – 6:30 pm, Tue - Fri 8:30 am – 3:30 pm
Customer Service: (302) 739-2134

New Castle County - Satellite Facility

State Police Troop Two
100 LaGrange Ave
Newark, DE 19702
(between Rts. 72 and 896 on Rt. 40)

By appointment only

Scheduling: (302) 739-2528 (local)
(800) 464-4357 (toll free)

Sussex County – Satellite Facility

Thurman Adams State Service Center
546 S. Bedford Street, Rm. 202
Georgetown DE 19947
(across from DelDOT & Troop 4)

By appointment only

Scheduling: (302) 739-2528 (local)
(800) 464-4357 (toll free)

Applicants in Delaware

1. If you are using the New Castle County or Sussex County locations, call **(800) 464-HELP (4357)** to schedule an appointment. No appointments are needed at the Kent County location.
2. Take the completed *Authorization for Release of Information* form to one of the offices listed above with the fee of \$65.00, to cover both the State of Delaware and Federal Bureau of Investigation criminal checks. Money orders and credit cards other than American Express are accepted at all locations. New Castle and Kent Counties accept cash; Sussex County does not accept cash. **Personal checks are not accepted in any county.** As fees are subject to change, contact the agency where you plan to submit your forms for current fees.

Applicants Not in Delaware (including Out-of-State or Outside the United States)

1. Your local police agency can fingerprint you. All types of fingerprint cards are accepted. Or, you may print a [FD-258 fingerprint form](#) available on the FBI website at www.fbi.gov – click *Services*, then *Identity History Summary Checks*, then scroll down to Option 1, Step 2, and click the link for *standard fingerprint form (FD-258)*. You may print the form on regular paper.
2. Your *Authorization for Release of Information* form and the fingerprint card must be complete. If identifying information is missing (such as name, date of birth, race, gender, etc.), your form will be returned.
3. **Mail** the *Authorization* form, fingerprint card, and *certified* check or money order (**personal checks are not accepted**) for \$65.00 made payable to “Delaware State Police” to:

**Delaware State Police
State Bureau of Identification (SBI)
PO Box 430
Dover, DE 19903-0430**

DO NOT SEND THIS FORM OR FEE TO YOUR PROFESSION'S BOARD OFFICE.
DO NOT SEND THIS FORM OR FEE TO THE DIVISION OF PROFESSIONAL REGULATION.
⇒ ALLOW FOUR WEEKS FOR RECEIPT OF RESULTS.



CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV
EMAIL: customerservice.dpr@state.de.us

AUTHORIZATION FOR RELEASE OF INFORMATION
CRIMINAL HISTORY RECORD CHECK FOR PROFESSIONAL LICENSURE APPLICANTS

Please print or type all information in black ink.

Check the type of license for which you are applying:

- | | | |
|--|--|--|
| <input type="checkbox"/> Adult Entertainment | <input type="checkbox"/> Mental Health (LPCMH, LCDP, LMFT, LAPCMH, LAMFT) | <input type="checkbox"/> Physical Therapy/Athletic Trainer |
| <input type="checkbox"/> Charitable Gaming Vendor | <input type="checkbox"/> Nursing (RN, LPN, APRN) | <input type="checkbox"/> Podiatry |
| <input type="checkbox"/> Chiropractic | <input type="checkbox"/> Nursing Home Administrator | <input type="checkbox"/> Psychology |
| <input type="checkbox"/> Dental | <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Real Estate Appraiser (includes Appraisal Management Company) |
| <input type="checkbox"/> Funeral | <input type="checkbox"/> Optometry | <input type="checkbox"/> Speech/Hearing |
| <input type="checkbox"/> Massage | <input type="checkbox"/> Pharmacy (includes key personnel of facilities licensed by Board of Pharmacy) | <input type="checkbox"/> Social Work |
| <input type="checkbox"/> Medical (Physicians, Physician Assistants, Respiratory Care Practitioners, Eastern Medicine Practitioners, Acupuncture Practitioners, Genetic Counselors, Polysomnographers, Midwifery Practitioners (CM, CPM)) | | <input type="checkbox"/> Texas Hold'em Individual |

Print your current full name:

Last Name First Name Middle Initial Suffix (e.g., Jr., Sr.)

Enter all other names you have used in the past (including, but not limited to, maiden name, former married names, alternative spellings):

1. _____
2. _____
3. _____
4. _____

As an applicant, I authorize release of any and all information that you have concerning my **CRIMINAL HISTORY RECORD INFORMATION**. I hereby release you, your organization, the State of Delaware and others from any liability or damage which may result from furnishing this information:

SIGNATURE OF PERSON PRINTED: _____ **Date:** _____

Phone: Home _____ Work _____

Mail the results of my criminal history request to:

**Division of Professional Regulation
861 Silver Lake Boulevard, Suite 203
Dover DE 19904
SLC D420A**

USE OF CRIMINAL HISTORY RECORD INFORMATION IS RESTRICTED BY LAW AND SHALL BE LIMITED TO THE PURPOSE FOR WHICH IT WAS GIVEN. MISUSE CONSTITUTES A CRIMINAL VIOLATION.